

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION AND LICENSING ADMINISTRATION**



References Letter

Dear: _____

Name of Home Care Agency

Address of Home Care Agency

_____ has made an application to operate a home care agency. The person has recommended you as a reference. Would you kindly fill out the form below to the best of your knowledge and return it to this office within five (5) working days.

Sincerely,

Sharon H. Mebane
Program Manager
Intermediate Care Facilities Division

Your Name: _____ **Occupation:** _____

Address: _____ **Telephone:** _____

How long have you known the applicant? _____ **Are you related?** Yes [] No []

Do you have any knowledge of the applicant's professional training or qualifications in providing care and/or supervision of vulnerable adults? Yes [] No []

If yes, please describe:

Have you ever been employed by the applicant? Yes [] No []

If yes, please describe:

Do you recommend the applicant to care for patients/clients who require nursing services?

Yes [] No [] **Why?** _____
